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AUTHOR Felton, Barbara J.; Revenson, Tracey A.
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ABSTRACT

While most lifespan developmental theories of personality predict age-related changes in coping, little direct evidence exists for determining whether age differences in coping style are due to intrinsic developmental processes or to age differences in the kinds of stresses encountered. To evaluate age differences in coping strategies and whether these differences are attributable to intrinsic, age-based developmental processes or to differences in the objective or subjective nature of the illness stresses, 170 chronically ill adults completed six scales assessing coping strategies and objective and subjective measure of illness stress. The subjects (67 males, 103 females) who suffered from hypertension, diabetes mellitus, rheumatoid arthritis, and systemic blood cancers, ranged in age from 41 to 89 years. The coping strategies studied were information seeking, cognitive restructuring, emotional expression, wish-fulfilling fantasy, threat minimization, and self-blame. A follow-up interview with 151 subjects was completed 7 months later. An analysis of the results showed that age differences in adults' styles of coping appeared in the areas of threat minimization and information seeking. People over age 75 were more likely to cope by cognitively minimizing the threat posed by the illness and less likely to cope by seeking out information about their illness and its treatment. Results are consistent with theories suggesting that late life represents a shift from active to passive mastery, and that older people are more likely to cope with stress through self-reliance than by reaching out to friends or professionals. (BL)

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Age Differences in Coping with Chronic Illness

Barbara J. Felton
New York University
New York, New York 10003

and

Tracey A. Revenson
University of California
Irvine, CA 92717

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ABSTRACT

While most life-span developmental theories of personality predict age-related changes in coping, little direct evidence exists for determining whether age differences in coping style are due to intrinsic developmental processes or to age differences in the kinds of stresses encountered. Chronic illnesses, although fairly prevalent among older adults, differ widely in the types of stresses which they impose. Thus, a sample of middle-aged and older adults faced with chronic illnesses varying in controllability and in types of adaptive tasks was studied to evaluate age differences in coping strategies and to investigate the question of whether or not these differences could be accounted for by differences in the nature of the stresses posed by the different illnesses. Age differences appeared in two of six coping strategies: people over age 75 were more likely to cope by cognitively minimizing the threat posed by the illness and less likely to cope by seeking out information about their illness and its treatment. While the nature of the illnesses and respondents' perceptions of the stresses of their illness were related to coping, controlling for these factors did not alter the relationship between age and coping. Results are consistent with theories suggesting that late life represents a shift from active to passive mastery. The findings are also compatible with evidence that current cohorts of older people are more likely to cope with stress through self-reliance than by reaching out to friends or professionals, an approach more characteristic of more recent cohorts of adults.

Age Differences in Coping with Chronic Illness

The concept of coping has received a great deal of interest recently as social gerontologists have sought to explain variations in individual well-being. Part of this interest has led to research on the consequences of coping (e.g., Felton et al., in press; Menaghan, 1982). Part of this interest has led to concern about the precursors of coping strategy use, i.e., the factors that lead people to use different coping strategies.

This paper considers age as a potential predictor of coping. Most theories of life-span development assume that the aging process affects the ways in which adults contend with life stresses (e.g., Fiske, 1980; Vaillant, 1977). And age-related changes in a variety of personality variables have been documented in cross-sectional and longitudinal studies (Fiske, 1980; McCrae, 1982; Neugarten, 1968); several such changes have been found in aspects of personality which seem particularly closely linked to coping styles (Clark & Anderson, 1967; Guttman, 1977).

Empirical research on coping strategies per se has documented modest relationships between age and coping (Folkman & Lazarus, 1980; McCrae, 1982; Pearlin & Schooler, 1978). Whether these changes are due to intrinsic developmental processes or to variations in the kinds of stresses that people face at different ages remains unclear. Research has shown that apparent sex differences in coping are largely accounted for by sex differences in the stressors faced (Folkman & Lazarus, 1980). Of more relevance, McCrae's (1982) recent study of coping styles shows that most age differences in coping can be attributed to age differences in the kinds of stresses which people face.

Chronic illness is a stressor which affects people of all ages but which is clearly most prevalent among late middle-aged and older people. Age affects the types of illness conditions which people encounter as well as people's perceptions of the kinds of stresses or "adaptive tasks" (Moos & Tsu, 1977) which their illness imposes. Because coping arises in response to the nature of the appraised stress (Lazarus, 1981), age-linked differences in actual and perceived experiences with illness make it reasonable to expect older people to cope differently with illness than younger people.

The current study examines age differences in coping and attempts to determine whether these differences are best attributed to intrinsic age-based developmental processes or to differences in the objective or subjective nature of the illness stress faced by people in these different age groups. Variations in the objective characteristics of the illnesses and, more importantly, in adults' perceptions of the adaptive tasks imposed by their illness are considered in order to see whether differences in these facets of stress do, in fact, account for age-related variation in coping.

METHODS

Procedure. The study was designed to allow comparisons among individuals faced with one of four chronic illnesses: hypertension, diabetes mellitus, rheumatoid arthritis, and systemic blood cancers (lymphoma, multiple myeloma, chronic lymphocytic leukemia). The illnesses were selected to represent a broad continuum of stressful situations, and theseillnesses, in fact, vary widely in their responsiveness to medical treatment, in the opportunities they provide for involvement in self care, and in the amount of pain and life threat which they entail.

Sample. Of the potential respondents referred by private physicians, hospital specialty clinics and a hypertensive screening agency, 170 individuals (75%) both fit the study criteria and consented to participate in the longitudinal study. Study criteria restricted selection to subjects who had a primary diagnosis of one of the four study illnesses, were over age 40, were currently under the care of a physician, and had no known psychiatric illness. The resulting sample was primarly white, married, middle to upper-middle class (67 men, 103 women), ranging in age from 41 to 89. The average length of time over which subjects had been diagnosed was 65 months. 151 patients completed the follow-up interview approximately seven months later. In this paper, analyses of time 2 data serve as replications to bolster confidence in conclusions.

Measures. The coping measures used consisted of six scales derived through factor analysis of a 55-item modification of the Ways of Coping scale reported by Folkman & Lazarus (1980). As measured here, coping is not viewed as intrapsychic defense mechanisms or personality styles, but as a set of cognitive, affective, and behavioral efforts to contend with illness stress. The six coping scales, with one exception, all fall under the rubric of emotion-focused or palliative strategies as described by Folkman and Lazarus (1980).

Information Seeking, the only instrumental or problem-focused coping strategy in this group, describes the individual's search for information and advice about the illness and its treatment. Cognitive Restructuring describes efforts at finding positive aspects of the illness experience, such as regarding the illness as an opportunity for inner growth or making social and/or downward comparisons in order to maintain an optimistic outlook. Emotional Expression is a coping response consisting of strong expressions of emotional strain, such as taking one's anger out at loved ones. Wish-fulfilling Fantasy describes an indulgence in pining or longing for the illness to go away or be over with. This strategy presumably provides a comforting escape into fantasy. The strategy of Threat Minimization, in contrast, invokes a refusal to dwell on thoughts about the illness and a conscious decision to set upsetting thoughts aside. The final coping strategy consists of attributions of Self-Blame.

Illness stress was measured by both objective and subjective variables. Objective indicators included the medical diagnosis and the length of time since the illness had been diagnosed. Subjective variables included an appraisal of the adaptive tasks of illness, a measure derived from an open-ended question asking respondents to describe the stresses that they had encountered in being ill. Answers to this question were content analyzed and produced ten categories of adaptive tasks. Eight differentiated among disease groups and were used in analyses: treatment demands, pain, disease-related symptoms other than pain, problems with social relationships, limited mobility, restricted life style, fear of death and of an uncertain future, and acceptance of the illness. Additional indicators of subjective illness stress included single item measures of the seriousness of the illness and its consequences and a ten-item index of health-specific locus of control (Wallston et al., 1976).

RESULTS

The first set of analyses consisted of assessments of bivariate relationships between age and coping. Pearson correlation coefficients and analyses of variance across four age groups at both time periods revealed evidence of age differences on two coping strategies. (See Table 1.) Information seeking showed significant differences at both times, with respondents over age 75 significantly less likely than others to seek out information about their illness as a means of coping [$F(3,147) = 3.64$, $p < .05$]. A trend ($p = .13$) at time 1 showed adults aged 75 and older were more likely than those aged 56 and younger to cope through threat minimization; at time 2, this trend reached standard levels of significance [$F(3, 146) = 3.66$, $p < .05$].

Hierarchical multiple regression analyses were used to determine whether age (measured continuously) was related to coping strategies even after controlling for medical diagnosis, a variable which describes, roughly but objectively, a full set of stress variations involved in these illnesses. To preserve a satisfactory cases-to-variables ratio and to clarify the roles of specific predictors, separate analyses were done for each control variable or control variable set. Results of this first set of multivariate analyses showed that the bivariate relationships between age and coping remained unaffected by medical diagnosis.

Our next step was to enter as an alternative index of stress the eight measures of the adaptive tasks posed by the illness. By virtue of being individually defined, these measures are more proximal indicators of stress and thus possibly more sensitive to individual differences and age-related differences in the experience of stress. Results (see Tables 2 and 3) show that the relationship between age and the coping strategy of information seeking was preserved. The weaker association between age and threat minimization proved significant at time 2 when adaptive tasks were controlled for. In addition at time 2, age proved to be related to the use of emotional expression; older people were

less likely than middle-aged adults to cope by venting their feelings.

These analyses were replicated using the other illness stress variables including the measure of the length of time since diagnosis, perceived seriousness of illness, and health locus of control measure. Results were largely unchanged, though emotional expression was less consistently related to age.

DISCUSSION

In this study, like most others to date, age differences in adults' styles of coping were limited in number. Only two of the six coping strategies examined here were significantly related to age, and these associations were not entirely consistent over the two time periods of the study. McCrae's (1982) research showed a similarly circumscribed set of age-related coping strategies. While most research, including that described here, has been limited to cross-sectional studies with the obvious restructions on interpretations, it seems safe to conclude that sweeping generalizations about large-scale shifts in coping strategies over the life span are not warranted.

On the other hand, there are some reasons that suggest that the age differences found in adults' use of information seeking and threat minimization ought to be taken seriously. For one thing, these relationships proved to be quite stable when considered in light of relationships between stress and coping. Despite the fact that theories and recent research on coping show people's selections of coping strategies to be largely shaped by the type of stress faced (e.g., Folkman & Lazarus, 1980), few of the illness stress variables considered here proved to be related to coping. And, more importantly, even fewer affected the relationship between age and coping. It <u>is</u> the case that only stresses associated with illness were considered here; in practical terms, however, the diversity of stresses represented in this study was quite large, ranging from the hassles of having to take oral medication to the severe stress of daily debilitating pain and/or the prospect of approaching death.

Another reason for taking these results seriously is that the kinds of age differences found are compatible with those coping strategies and personality factors found in other studies to be related to age. Gutmann's (1977) description of shifts from active to passive mastery fit particularly well with the evidence here of a disinclination among adults over age 75 to cope by seeking out information about their illnesses or by ventilating their emotions and more inclined to cope by mentally minimizing the amount of threat posed by their illness. Cohort variation in preferred modes of coping may also play a role here: Veroff and his colleagues (1981 a,b) found that self-reliance, which seems to include a threat minimization process like that described here, was characteristic of adults who were middle aged in 1957 and elderly in 1976. Younger cohorts showed a preference

for coping by seeking out assistance -- either in the form of information or emotional support -- from others. While the roles of cohort effects and of developmental shifts have yet to be clarified, we are beginning to etch a portrait of the kinds of coping styles which are age-related.

REFERENCES

Clark, M. and Anderson, B. G. Culture and aging in an anthropological study of older Americans. Springfield, Ill.: Charles C. Thomas, 1967.

Costa, P.T., Jr., and McCrae, R.R. An approach to the attribution of aging, period, and cohort effects. Psychological Bulletin, 1982, 92, 238-250.

Felton, B. J., Revenson, T. A., & Hinrichsen, G. A. (in press). Coping and adjustment in chronically ill adults. Social Science & Medicine.

Folkman, S. and Lazarus, R. S. An analysis of coping in a middle-aged community sample. Journal of Health and Social Behavior, 1980, 21, 219-139.

Gutmann, D. L. The country of old men: Cross-cultural studies in the psychology of later life. In R. A. LeVine (Ed.), Culture and Personality. Chicago: Aldine, 1974.

Lazarus, R. S. (1981). The stress and coping paradigm. In C. Eisdorfer, D. Cohen, A. Kleinman & P. Maxim (Eds.), Models for clinical psychopathology. New York, Spectrum.

McCrae, R. R. Age differences in the use of coping mechanisms. Journal of Gerontology, 1982, 4, 454-460.

Moos, R. H. & Tsu, V. D. (1977). The crisis of physical illness: An overview. In R. H. Moos (Ed.), Coping with physical illness. New York: Plenum.

Menaghan, E. G. Measuring coping effectiveness: A panel analysis of marital problems and coping efforts. Journal of Health and Social Behavior, 1982, 23, 220-234.

Pearlin, L. I., & Schooler, C. (1978). The structure of coping. ~~Rhw areuxruew od expinf.~~ Journal of Health and Social Behavior, 19, 2-21.

Veroff, J., Kulka, R. A., & Douvan, E. Mental health in America: Patterns of help-seeking from 1957 to 1976. New York: Basic Books, 1981.

Wallston, B S., Wallston, K.A., Kaplan, G. D. & Maides, S.S. (1976). Development and validation of the health locus of control (HLC) scales. Journal of Consulting and Clinical Psychology, 44, 580-585.

Table 1

Mean Levels of Coping Strategy Use as Reported by Chronically Ill Adults

		Age 40-54 (N=39)		Age 55-64 (N=54)		Age 65-74 (N=43)		Age 75+ (N=10)	
		Mean	s.d.	Mean	s.d.	Mean	s.d.	Mean	s.d.
		Mean	s.d.	Mean	s.d.	Mean	s.d		
Cognitive Restructuring[1]	(Time 1)	2.89	.81	2.88	.68	2.82	.71	2.64	.93
	(Time 2)	3.13	.54	3.02	.70	3.10	.62	3.07	.97
Emotional Expression	(Time 1)	2.33	.80	2.22	.65	2.07	.72	1.92	.51
	(Time 2)	2.44	.58	2.29	.57	2.18	.58	2.13	.55
Wish-Fulfilling Fantasy	(Time 1)	2.91	.97	3.02	.92	2.78	1.00	2.50	1.18
	(Time 2)	2.96	.81	3.15	.88	2.94	1.02	2.63	.88
Self-Blame	(Time 1)	1.79	.69	1.60	.59	1.46	.54	1.54	.67
	(Time 2)	1.78	.67	1.70	.62	1.63	.58	1.40	.49
Information Seeking	(Time 1)	2.78	.92	2.61	.89	2.45	.80	1.81	.85
	(Time 2)	2.84	.83	2.67	.77	2.57	.73	2.65	.66
Threat Minimization	(Time 1)	3.45	.68	3.24	.60	3.45	.72	3.67	.68
	(Time 2)	3.43	.69	3.35	.62	3.62	.59	3.97	.73

[1]Coping scale ranges are from 1 to 5; scores on each scale have been divided by the number of items in each scale.

Table 2

Hierarchical Multiple Regression of Adaptive Tasks and Age on Coping Strategy Use

	Adaptive Tasks		Age		Total Variance	
	R^2	F^a	ΔR^2	F^b	R^2	F^c
Cognitive Restructuring	.076	1.66	.010	1.82	.086	1.68+
Emotional Expression	.008	1.37	.043	7.64**	.104	2.06*
Wish-Fulfilling Fantasy	.133	3.08**	.005	.96	.138	2.83**
Self-Blame	.038	.80	.018	3.10+	.056	1.05
Information Seeking	.088	2.05*	.051	9.50**	.139	2.88**
Threat Minimization	.127	2.93**	.006	1.08	.133	2.73**

[a] df=8, 160 [b] df=1,160 [c] df=9,160

** p .01 * p .05 + p ~ .10

Table 3

Hierarchical Multiple Regression of Adaptive Tasks and Age on Coping Strategy Use: Time 2

	Adaptive Tasks		Age		Total Variance	
	R^2	F^a	ΔR^2	F^b	R^2	F^c
Cognitive Restructuring	.095	1.62	.001	.17	.096	1.65
Emotional Expression	.048	.97	.025	4.17*	.073	1.23
Wish-Fulfilling Fantasy	.097	2.04*	.011	1.81	.108	1.88+
Self-Blame	.079	1.64	.011	1.73	.090	1.54
Information Seeking	.045	.89	.012	2.71	.061	1.02
Threat Minimization	.019	3.03**	.035	5.58*	.054	.89

[a] df=8, 140 [b] df=1. 140 [c] df=9, 140

** p .01 * p .05 + p ~ .10